Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION DISMISSAL

PART I: GENERAL INFORMATION

Requestor's Name and Address:

DR. ALAN J. RECHTER, M.D.
ORTHOPEADIC ASSOCIATES
P.O. BOX 201576
DALLAS, TX 75320-1576

MFDR Tracking #: M4-10-0127-01

Respondent Name and Box #:

TEXAS MUTUAL INSURANCE CO.
REP. BOX #: 54

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Claim filed prior to timely filing issue."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $4,490.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "…Texas Mutual received the billing 5/26/09, audited the bill, and concluded the billing was untimely. The date in Box 31 of the requestor's bill is 5/20/09… When 11/23/08 is subtracted from 5/20/09, the remainder is greater than 95, which means the billing is not consistent with DWC Rule 133.20. The requestor requested reconsideration of the initial bill. Texas Mutual received this 7/20/09. The requestor submitted a screen print from its billing system along with an explanatory letter of 7/15/09. However, neither of these separately or together was sufficient to convince Texas Mutual the billing was submitted timely. The screen print shows the bill was paper and it indicates the transmittal date was 12/12/08. The top of the print has the claimant's name and the middle screen lists the doctor's name. It would be helpful if there was further information regarding the transmittal process. Absent such, however, the requestor has not provided sufficient information to show the bill was timely filed. For this reason Texas Mutual cannot issue payment…"

Principal Documentation:

1. Response to DWC 60

PART IV: DISPUTED SERVICES

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
11/23/08	CPT Codes 99283-57, 24546, 64718, 76000-26-59	CAC-B5. CAC-29, 724, 731	1 – 4	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines,* and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

Under the provisions of Section 413.031 of the Texas Worker's Compensation Act, Title 5, Subtitle A of the Texas Labor Code, and Commission Rule 133.307 (Titled Medical Dispute resolution of a Medical Fee Dispute) effective January 1, 2003, a request for dispute resolution was received by the Medical Review Division regarding a medical payment dispute between the requestor and the respondent named above.

An initial review by the Medical Fee Dispute Resolution Division has determined the following::

1. These services were denied by the Respondent with reason codes:
   - CAC-B5 – Coverage/program guidelines were not met or were exceeded.
   - CAC-29 – The time limit for filing has expired.
   - 724 – No additional payment after reconsideration. Network contract applied by Texas Start network.
   - 731 – 134.801 & 133.20 provider shall not submit a medical bill later than the 95th day after the date of service, for services on or after 9/1/05.

2. The Division has determined that good cause exists to dismiss this request based on : Information on the Explanation of Benefits dated 08/05/2009 from Requestor to Respondent reflects that a negotiated workers' compensation health care network contractual arrangement was in effect. The Texas Star Network was contacted and both the Requestor and injured employee are in the Texas Star Network. In accordance with the Texas Labor Code 413.011 (d-1), the Division does not have jurisdiction to review network contractual arrangements under Chapter 1305 of the Texas Insurance Code.

3. Dismissal of the dispute is authorized by 28 TEX. Admin. Code Section 133.307(e)(3)(f).

4. It is the conclusion of the Medical Review Division that this case be dismissed without any additional action being taken.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202 Section 133.307(e)(3)(f)
Texas Government Code, Chapter 2001, Subchapter G.

PART V: DISMISSED

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Division has no jurisdiction for adjudication of this dispute and it is dismissed.

DISSMISSED BY:

Authorized Signature	Medical Fee Dispute Resolution Officer	November 23, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.